

## Chapter 9: Aboriginality, Poverty and Health—Exploring the Connections

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### Introduction

In the broader context, poverty and poor health are incontrovertibly linked. The research evidence of inequality of health between the poor and the non-poor is overwhelming. Moreover, this pattern equally applies in affluent countries such as Australia, where a clear and widening health gap exists between low and higher income groups (Mathers 1994; Walker 2000). Within these data, the disparity between Aboriginal<sup>1</sup> and non-Aboriginal Australia, in both health and income status, is also long established (Saggers & Gray 1991; ABS 2003). Using a social determinants of health approach, we might rationally conjecture that poverty is a core explanation for Aboriginal ill health.

The elemental role of social–structural determinants in population health is neatly summarised into ten core factors by Wilkinson and Marmot (2003). These are: the social gradient; stress; early life; social exclusion; work; unemployment; social support; addiction; food; and transport. A correlation is easily detected between each determinant and the relative position of Aboriginal people in Australia's socio-economic hierarchy. From the lowly position of the vast majority of Australian Aborigines on the social gradient the applicability of the social determinants of health to Aboriginal Australia appears obvious. These include the psychosocial stress inherent in Aboriginal people's lives; the low birth weights, poor maternal health and heavy burden of disease experienced by Aboriginal children; the historical and ongoing exclusion of Aboriginal people from social institutions and access to social resources; the high rates of unemployment and relegation of most Aboriginal workers to low-level, insecure market work; the high levels of addiction present in many Aboriginal communities; the inability of many Aboriginal communities and families to consistently access good food; and the limited transport options available to a majority of Aboriginal people.

It is also not hard to identify poverty as a recurring theme. The above social determinants can be directly connected to poverty at the individual and population group level. Despite this obvious link, the association between these two concepts may not be that simple. There are grounds for questioning any presumption of a linear relationship between Aboriginal health and Aboriginal poverty. First, many of the concepts and assumptions inherent in current models of social determinants of health are not directly applicable to the cultural, social or political milieu of the lives of Aboriginal people (Hunter 1999; Morrisey 2003). Second, poverty is a complex phenomenon that encompasses a

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<sup>1</sup> This paper uses the term 'Aboriginal' when discussing Australian Aboriginal peoples in preference to the more commonly used terms 'Indigenous' or 'Aboriginal and Torres Strait Islander' in recognition of the fact that many Australian Aboriginal people find these terms problematic.

multitude of deprivations and is not the exclusive domain of low income or income inequality. Third, and more critically, the concept of poverty is significantly more complex when examined within the context of Aboriginal Australia.

In exploring the theoretical and empirical relationship between poverty and ill-health, this paper takes as its frame the multi-dimensional, and arguably different, nature of Aboriginal poverty. It is proposed that a core aspect of the analysis of Aboriginal health, within a social determinants of health model, is Aboriginality, itself. The term Aboriginality is used in this paper in the wider sociological sense, referring to the lived experience of being an Aboriginal person in contemporary Australia and the broader impact of that lived experience on individual and group life chances and life options. Contemporary theoretical debates on the nature of the link between income inequality and health are also examined for their relevance and possible contribution to broadening our understanding of the relationship between Aboriginal poverty and health inequity.

### **Measuring and defining Aboriginal poverty**

In Australian studies of poverty, definitions of what constitutes poverty and who is poor are not straightforward. Poverty is variously defined, conceptualised and operationalised across a broad range of measures. There are also significant methodological and/or ideological debates about how poverty is measured. Poverty indicators are, fundamentally, constructions based on subjective judgments rather than objective phenomena. As such they can be, and frequently are, contested, often along ideological lines (Saunders 2005). Irrespective of these debates, however, the over-representation of Aboriginal people among the economically deprived and the low level of material wellbeing in Aboriginal households and communities is undisputed. The literature suggests that Aboriginal poverty is widespread, deeply entrenched and probably underestimated (Western 1983; Graetz & McAllister 1988; Hunter 1999; Morrissey 2003). To provide context for later discussion, and to develop a picture of the depth and breadth of Aboriginal poverty, it is worth providing an overview of Aboriginal economic disadvantage from a range of poverty perspectives.

### ***Income inequality comparison***

While cash income is a blunt measure of poverty, direct income is a key component of household resources. From an income base, Aboriginal households are clearly much poorer than others in Australia. Recent data from the Australian Bureau of Statistics (ABS) (2005) confirm that the average weekly gross mean income for Aboriginal households remains at around 60 per cent of that of non-Aboriginal households. This basic comparison, however, does not reveal the depth of the comparative income deprivation of Aboriginal Australia. Hunter (1999), using a range of equivalence scales to adjust for both the larger size of Aboriginal households and the variability of equivalence scales, found

that regardless of the scale used Aboriginal households were more than twice as likely to have incomes below 40 per cent of the national median than non-Aboriginal households <sup>2</sup>. Examining the same data from the individual income unit perspective, again using an equivalence scale to take account of the number of people dependent upon each income unit, a third of Aboriginal people had income below 40 per cent of the median compared to less than 10 per cent of all Australians. Also, the comparative income inequality of Aboriginal Australians does not appear to be improving. Altman and Hunter (2003) find that the disparity of Aboriginal to non-Aboriginal individual income actually increased in the decade 1991–2001.

### ***Socio-economic comparison***

Widening the examination of poverty to include measures of socio-economic position, the comparative picture is no less bleak. As these and the additional data in Table 1 below indicate, on almost any measure of social or economic wellbeing Aboriginal people are significantly poorer than other Australians. On broader measures of socio-economic inequality, Aboriginal people are: more than fifteen times as likely to be imprisoned as adults; seventeen times as likely to be detained as juveniles; and have comparative rates of homelessness more than three times those of non-Indigenous Australians (Bareja & Charlton 2003; ABS 2004a; ABS 2005).

**Table 1: Socio-Economic Indicators: Aboriginal and Non-Aboriginal Populations**

	Aboriginal %	Non- Aboriginal %
Unemployment rate	20	6
Employed in non CDEP job*	38	74
Apparent year 12 retention rate	39	77
Hold a Bachelor Degree or above	5	21
Rent social housing	38	6
Homeowner/purchaser	31	70
Has welfare payments as main source of income	52	27
Would be unable to raise \$2000 within a week	54	14
Proportion with income in lowest and second quintiles	72	39
Proportion with income in the highest quintile	5	20

Sources: ABS 2002; ABS 2004b; ABS 2005

\* CDEP (Community Development Employment Program) jobs are welfare payment linked positions.

<sup>2</sup> Households variation in size and composition impacts on the resources needed for economic well-being. Equivalence scales allow for the direct comparison of different households by weighting a household according to its members. Factors commonly taken into account in assigning the weighting values are the size of the household and the age of its members, such as whether the members are children or adults.

The employment indicators included in Table 1 should also be interpreted within the context of the broad segregation of the Aboriginal labour market across occupational type and employment sectors. Only 21 per cent of employed Aboriginal males hold professional/associate professional or managerial positions compared to 41 per cent of employed non-Aboriginal males. Within sectors, a far larger proportion of the Aboriginal workforce is in government employment (43 per cent compared to 17 per cent) and despite more than a decade of strong private sector job growth, Aboriginal employment in this sector has declined since 1991 (ABS 2001).

### ***Absolute and relative poverty comparisons***

In developed nations, a relatively high standard of living means that poverty literature concentrates on relative rather than absolute measures of poverty. The social determinants literature also tends to a relative view of poverty, proposing that in developed countries, such as Australia, health is related to relative rather than absolute income (Wilkinson 1999). However, using the United Nations (1995 cited in Harris, Nutbeam & Sainsbury 2001:260) definition which defines absolute poverty as ‘severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services’, the evidence suggests that a significant number of Aboriginal people experience absolute poverty. For example, nearly two-thirds of discrete Aboriginal communities are reliant on bore water for their water supply. In 2001, 35 per cent of those communities experienced water restrictions, 26 per cent had water supplies that failed testing for water safety and a further 8 per cent did not even have their water tested (ABS 2003). The existence of absolute poverty is also evidenced by the commonality in many Aboriginal communities of easily treatable diseases associated with inadequate basic sanitation and living conditions such as scabies and diarrhoea (Saggers & Gray 1991).

Given the previous table outlining the comparative position of Aboriginal people in Australia’s socio-economic hierarchy, relative poverty as defined below, obviously applies to a significant proportion of the Aboriginal population:

... being unable to afford the goods, services and activities (eg, housing, food, clothes, recreation, social obligations) that allow people to play the roles, participate in the activities and relationships and follow the customary behaviours that are considered normal in society and expected of people by virtue of their membership of society (Townsend 1993 cited in Harris, Nutbeam & Sainsbury 2001: 260).

The absolute and relative dimensions of poverty are also important in how Aboriginal poverty is interpreted and understood. Altman (2004) demonstrates this key difference in an examination of measures of Aboriginal poverty between 1972 and 2001. In *absolute* terms, Aboriginal socio-economic indicators show improvement in the areas of housing and education. However, in the same period, unemployment rose and the proportion of the Aboriginal population aged older than fifty-five years remained static. Comparative analyses of those same statistics relative to those of non-

Aboriginal Australia provide different results. Comparatively, the gap between Aboriginal and non-Aboriginal unemployment has decreased, as have the indicators around education. However, comparative mean income has remained at about 60 per cent of the non-Indigenous population, employment indicators have also remained static and the comparative proportion of Aboriginal to non-Aboriginal people aged older than fifty-five has actually declined. While both analyses confirm on-going Aboriginal poverty, the interpretation of whether Aboriginal socio-economic conditions are improving or declining, and in what areas, can depend on whether the focus is on exploring absolute or relative improvement.

## **Dimensions of poverty versus measuring poverty**

The well-established statistical relationships between health inequality and income inequality can lead to poverty being viewed in somewhat simplistic terms (Harris, Nutbeam & Sainsbury 2001). A key reason is that the common indicators of poverty, such as low income or socio-economic status, tend to limit our conceptions of what poverty is. The problem here is that such indicators are just that—proxies of poverty that enable some limited aspects of poverty to be measured in statistically comparable ways. Recognising this essential difference between measures of poverty and poverty itself is important in avoiding the common pitfall of confusing proxies of poverty for literal definitions of ‘poverty’. Poverty is a much more complex phenomenon than any of its individual proxies can indicate.

How then might we develop a more detailed picture of poverty? Given that poverty, in general, refers to ‘lack’ it might be easier to examine poverty in terms of what it is not: material wellbeing. Material wellbeing, defined by Richardson and Travers (1993:1), is ‘that aspect of human well-being which can be affected by a change in produced goods and services’ and is essentially concerned with a material standard of living. A brief look through the literature on this topic reveals the following list of what might be considered as factors in material wellbeing: cash income; home production; non-market work; non-cash government benefits; indirect tax concessions; home ownership—imputed rent and capital gains; standard of housing; value of leisure; government services (i.e. health and education); infrastructure; social cohesion; family and social networks; and autonomy (Richardson & Travers 1993; Harding 1998; Johnson 1998). In addition, material wellbeing also incorporates aspects of living that are not easily named or measured, such as quality of life or opportunity for future prosperity. For Aboriginal people, we might add dimensions such as cultural recognition, choice of lifestyle, capacity to self-determine, community control and land rights, to name just a few. The list, therefore, is almost endless, and this is the point. Just like material wellbeing, its opposite—poverty—is multi-factorial and is contributed to, and impacted upon, by an almost endless list of factors.

Conceptual problems in applying standard measures of poverty to Australia's Aboriginal peoples also hinder our ability to gain an accurate picture. Valid information on Aboriginal poverty is relatively scarce, limited until recently to census data and the more unreliable data from administrative sources such as government departments or community agencies. Demographic factors such as age structure differentials, geographic distribution of the population, significant differences in household structure and size, and cultural aspects such as the role of non-market work, constrain the comparability and understanding of the data that are collected. Additionally, many of the variables used within the ABS standard index of socio-economic disadvantage 'do not provide unambiguous and/or culturally appropriate measures of socio-economic disadvantage for Aboriginal Australians' (Gray & Auld 2000:v). For example, while Hunter (1999) uses a variety of equivalence scales to improve comparability between Aboriginal and non-Aboriginal households, all current equivalence scales are based on presumptions about the Western, nuclear family. Further, as Hunter, Kennedy and Biddle (2002) discover, the choice of equivalence scale can significantly reduce or increase the comparative level of Aboriginal poverty. Gray and Auld (2000) also conclude that while constructing a composite index of Aboriginal relative socio-economic disadvantage is possible, the usefulness of such an index is severely limited first, by the changeability of outcomes according to the variables included in the index, and second, by the place-specific relevance of many standard indicators such as education or employment.

### ***The multi-dimensional nature of aboriginal poverty***

For Aboriginal Australia we need to rethink the dimensions of poverty. Hunter (1999) empirically establishes that Aboriginal poverty is multi-faceted with facets that are not directly related to income or lack of it. In this analysis overcrowding in housing is an issue for relatively advantaged Aboriginal families, as well as those on lower incomes; negative interactions between Aboriginal people and the criminal justice system are a common feature of Aboriginal life regardless of household income, with members of high-income Aboriginal households being nineteen times more likely to have been arrested than their non-Aboriginal counterparts; and dislocation from traditional lands is a common experience in Aboriginal households, irrespective of income. Most importantly for this paper, in the area of health high-income Aboriginal families are nearly as likely to experience long-term health problems as low-income Aboriginal families. Hunter's analysis, while limited by data availability, emphasises both the multi-dimensional nature of Aboriginal poverty as well as its essential differences from the poverty of other poor Australians.

From a social determinants perspective, to understand why this is so we need to ask the question within the context of the socio-political and material reality of Aboriginal people's lives. Not only is Aboriginal poverty different but so is Aboriginal material wellbeing. In the non-Aboriginal population, higher income tends to be intergenerational, reflecting a whole of life-course material advantage.

Conversely, for Aboriginal people higher income is, to use medical terminology, almost entirely late in onset and often self-attenuating. That is, while some Aboriginal households record annual incomes in higher level brackets in cross-sectional data collections, such as a census or NATSIS (National Aboriginal and Torres Strait Islander Surveys), these data cannot be assumed to be both an indication of life-course advantage or as a proxy for other middle-class attributes, such as better health or educational outcomes. Without longitudinal data it is impossible to estimate what proportion of Aboriginal households retain their higher income status over data collection periods. Given that much Aboriginal higher income employment is located in Aboriginal-specific positions, such employment is often temporary in nature. Unlike other Australians in higher income brackets, loss of that employment will likely lead directly back to low income, rather than another job with another employer at similar or higher wages.

### **The domain of Aboriginality and Aboriginal poverty**

Bill Tyler (1990) notes that Aboriginality occupies an ambiguous position within the dominant discourse on Australian studies of poverty and social stratification. While Aboriginal material disadvantage is regularly described, the literature rarely includes any causal exploration of *why* Aboriginal people consistently occupy the lowest rung of the Australian socio-economic hierarchy. Rather, Aboriginal poverty tends to be treated as another category of the poor, along with other traditionally disadvantaged groups such as migrants and sole parents. Poverty analyses are usually limited to a survey of historical inequalities and economic factors such as continuing education, employment and housing inequities. Aboriginality, as a causal element, is primarily unaddressed. Aboriginal people, families, households and communities do not just happen to be poor. Just like socio-economic advantage, socio-economic deprivation accrues and accumulates across and into the life and related health chances of individuals, families and communities. Data relating to Aboriginal poverty must be placed and analysed within their present and past social-structural context—a context that is uniquely Aboriginal. The then and the now are connected. The historic and contemporary consequences of Aboriginality impact on an individual's or a family's ability to access the economic, social, cultural and human capital resources of our society.

The key question here is whether being an Aboriginal person in Australia is a structural component, in itself, that impacts on an individual's life and health chances. This proposition does not mean that factors such as low income, low educational attainment and limited employment options are not important—just that they must be understood within a framework of Aboriginality. Crucially, Aboriginality is not just an added component—these factors plus Aboriginality. Rather, Aboriginality is the central core with other aspects of poverty intimately interwoven and interpreted through that Aboriginality. The domain of Aboriginality encompasses Aboriginal poverty. This dynamic might be expressed, albeit inadequately, in equation terms as:

$$\text{Aboriginal poverty} = \text{The Domain of Aboriginality} * (\text{low income} + \text{low education level} + \text{limited work skills} + \dots)$$

The interrelationship of Aboriginal arrest, employment and poverty rates provide an illustration of this concept. In a recent study, Hunter and Borland (1997) found that following the experience of arrest the chance of Aboriginal males finding employment was reduced by up to 20 per cent. Data from New South Wales also found that in 2001 nearly one in five Aboriginal men, or two in five for those aged twenty to twenty-four years of age, were charged with a criminal offence (Weatherburn, Lind & Hua 2003). Therefore, while arrest is also likely to have negative employment consequences for non-Aboriginal men, the rate of arrest among Aboriginal males turns a private issue into a population-level, poverty-inducing problem.

### **Aboriginal poverty as a causal factor in Aboriginal health**

Does the unique nature of Aboriginal poverty mean that a social determinants approach has no relevance in explaining Aboriginal health inequality? The answer, in short, is that we do not know. There is no empirical base from which to assess the applicability of social determinants models to Aboriginal health. As discussed in Hunter's analysis, no statistical association was found between income level and health—Aboriginal people had poor health across all income distribution levels. Theoretically, however, the complex multi-factorial nature of Aboriginal poverty and the role of Aboriginality itself mean that existing models can only ever offer, at best, partial explanations of the complexity of the interaction between Aboriginal poverty and health. As proposed, Aboriginality adds a dimension or, more accurately, a frame that cannot just be plugged into existing mainstream models. Although these limitations are formidable, broader theoretical work can still provide valuable insights for Aboriginal-specific research and theory development. The following section examines a range of health and poverty theoretical frameworks and how these might apply to understanding the social determinants of Indigenous health.

### ***The role of culture in poverty and health outcomes***

Ethnicity or cultures are only briefly considered within the broader social determinants of health literature. For example, Shaw, Dorling and Davey-Smith (1999) pursue ethnicity as a separate, but interrelated, determinant of health, while Eckersley (2001) points to the influence of Western cultural determinants as the missing factor in social determinants of health literature. Neither discussion includes Indigenous references. Outside the social determinants literature, however, Aboriginal culture and cultural practices as factors in both disparate health and poverty outcomes are the subject of theoretical and political debate. As such, two different perspectives on culture are discussed below:



one revolves around the role of Aboriginal culture in producing poor health outcomes and the other looks to culture as an explanatory factor in current discourses around Aboriginal poverty.

### ***A poverty of culture?***

The first perspective theoretically pairs Aboriginal culture and poor health by pointing to the impact of cultural practices on health outcomes. For example, Sutton (2005:8), arguing against what he terms the ‘politicisation of disease’, states that ‘culturally transmitted behaviours and attitudes lie at the centre of the huge differences between Aboriginal and non-Aboriginal health outcomes’. The argument’s base is that Aboriginal cultural practices deriving from the ‘pre-existing social and economic organisation of the people concerned’ clash with contemporary Aboriginal environmental circumstances (2005:3). For instance, Sutton links overcrowded housing and unhygienic sleeping conditions with previous camping patterns of semi-nomadic Aboriginal residential groups.

On one level, Sutton’s argument on the impact of culture on Aboriginal health has social determinants merit. Poor living conditions and overcrowding are undoubtedly associated with a higher burden of disease. However, positing these living conditions as primarily the result of culturally inspired choice, rather than related to poor infrastructure and lack of choice, is not empirically established by Sutton. On the other hand, health-related lifestyle factors—such as misuse of alcohol and other drugs, smoking and poor diet or resistance to incorporating healthy lifestyle practices into daily living—can be directly connected to poor health outcomes. But while these behaviours may have cultural elements, do they specifically derive from Aboriginal culturally embedded practices? Such behaviours are certainly not exclusive to Aboriginal people or universal within Aboriginal populations. Eckersley (2005), for example, points to the role of modern Western culture in alcohol and drug abuse at the broad community level. The diversity of Aboriginal cultures and lifestyle of populations also complicate any positioning of Aboriginal culture as a *key* explanatory factor in health inequality. Nearly one-third of Aboriginal people reside in Australia’s larger cities (ABS 2005) and poor health outcomes are endemic (as is poverty) across specific cultural practices, belief systems and geographic location.

More critically, the positing of Aboriginal culture and cultural activities as a central causal explanation for Indigenous health inequality is not theoretically sustained. The key critique is the flexible use of the concept of Aboriginal culture to encompass a myriad of differentially occurring factors that may impact upon Aboriginal health. For example, in outlining problematic culturally embedded Aboriginal practices, Sutton (2005:2) conflates specific health-damaging activities such as poor diet, poor personal hygiene and substance misuse with infrastructure issues such as domestic sanitation and housing density. He then also adds the nebulous concepts of Aboriginal care of children and the elderly, general relationships, conflict resolution, cultural norms to do with the expression of emotion, and attitudes to learning new information to the one undifferentiated list. The arbitrary designation of

specific health issues, structurally embedded factors, and undefined attitude and value items as 'culture' results in a confusion and conflation of cultural practices, structural conditions and the social, cultural, political and economic environments in which Aboriginal people live their lives. The squeezing of such a plethora of areas into the 'culture' bag stretches the concept of culture almost to meaninglessness, depriving it of its heuristic validity. While some Aboriginal cultural practices unquestionably contribute to poor health outcomes, empirical research is required to identify and determine the relevance and role of Aboriginal culture to a social determinants of Aboriginal health perspective.

### ***A culture of poverty***

Sutton's thesis, discussed above, links broadly into theories proposing culture as a causal explanation for poverty. Initially developed during the 1960s by American anthropologist Oscar Lewis, the culture of poverty is defined as 'a sub-culture with its own structure and rationale, as a way of life which is passed down from generation to generation along family lines' (Lewis 1967: xxxix cited in Lister 2004:106). The thesis, therefore, links poverty to the social and cultural attributes, attitudes and value systems of the poor. Although Lewis emphasised that this culture functioned as an adaptation and reaction of the poor to their marginal position in unequal societies, the concept of a 'culture of poverty' that is developed and maintained generationally by the poor themselves, and who are different in their values and attitudes and beliefs from the non-poor, found widespread public and political appeal. As such, variations have regularly reappeared in popular and political discourses around poverty. During the 1980s and early 1990s it was the concept of a cycle of deprivation which focused on the intergenerational transmission of deprivation through the transmission of attitudes, values and behaviours. The current expressions of the culture of poverty thesis are the related notions of an underclass and welfare dependency (Lister 2004).

For Aboriginal people, the concept of welfare dependency has a particular relevance. In what Altman (2004) refers to as discourse of crisis, Aboriginal people are now labelled as problematically welfare dependent and welfare dependence is linked causally with Aboriginal poverty. As in the broader discourse on welfare dependency, dependency is negatively linked with personal deficits such as passivity, laziness, drunkenness and poor parenting (Smiley 2001). For Aboriginal people, culturally linked values about the relevance of employment as well as the social dysfunction apparent in many Aboriginal communities are added. The outcome is Aboriginal-specific welfare reforms implemented with the stated intention of 'breaking the welfare cycle in many Aboriginal communities' (Lewis 2005:2). The focus on eliminating welfare dependence incorporates an assumption that removing dependence on welfare payments will result in the opposite of dependency: autonomy, personal responsibility and function.

The critical question here is not whether levels of Aboriginal reliance on welfare payments are acceptable. With more than half of all Aboriginal people (52 per cent) listing government benefits and pensions as their main source of income (ABS 2005), such reliance is obviously problematic. The often ambivalent relationship between Aboriginal people and the welfare system has also long been a topic of concern among Aboriginal activists (see Pearson 2000; Yu 1994; Perkins 1990, for example). Moreover, critiquing the application of the welfare dependency label to Aboriginal people living in poverty is not an argument against welfare reform *per se*. Instead, the critical question is whether welfare dependence is the core explanation for the deeply entrenched and unrelenting nature of Aboriginal poverty. There are currently no data available to ascertain the extent to which persistent Aboriginal inequalities reflect Aboriginal choice (Rowse 2002). And, as Lister notes (2004:110), as with the earlier culture of poverty and cycle of deprivation theses, the mainstream empirical research does not support welfare dependency as either the creator or intergenerational maintainer of poverty (for an Australian example see Pech & McCoull 2000).

### ***Structure or agency or both?***

The two theses discussed above, despite their deficits from a social determinants perspective, do raise the central question of the role of personal agency. Examining culture in tandem with health or poverty-related behaviours alerts us to the danger of seeing all Aboriginal health and poverty outcomes in purely structural terms. A social determinants perspective can risk what Kowal and Paradies (2005:1352) refer to as over-structuration, whereby the role of structural factors is over-emphasised and the role of individual agency is under-emphasised in choosing specific practices and behaviours. The question to be asked, then, is to what extent can poverty and ill-health, as social outcomes, be defined as a product of the autonomous, purposive action of human agency, or as a product of social, economic and political processes and structures? The answer to this basic structure/agency question is irretrievably complicated by the embeddedness of individual behaviour in the broader socially structured environment. Choices at the individual level are not made in a vacuum. The social, political and economic milieu in which an individual, or a group of people, lives enhances or constrains their capacity for social agency.

According to Giddens (1991), the key to ascertaining the respective roles of agency or structure as an explanatory factor in social phenomena such as poverty or ill-health is found in the extent to which a group has the power to exercise control over their own lives despite their subordinate position in wider hierarchical political, economic and social power relationships. The evidence presented in this paper on the depth and breadth of Aboriginal deprivation in contemporary Australia, and the uniquely constraining nature of Aboriginality on the capacity of Aboriginal people's individual and group life-chances and options, indicate little opportunity for Aboriginal people to be what Giddens refers to as 'authors of their own biographies' (1991:127). Therefore, just as over-structuration can over-

emphasise social structure, theories that focus on individualised explanations, such as personal or cultural inadequacies, can result in an over-reliance on personal agency as an explanation of health or poverty inequalities. Without the power to change life circumstances or to overcome or eliminate structural constraints, allocating the cause of poverty or health disparities to personal agency or cultural choices risks pathologising poor Aboriginal people, adding stigma and shame to unyielding inequality.

The positioning of cultural deficits and poor individual decision making as central explanatory factors also highlights the fact that, as a concept and as a lived reality, poverty is a social relation. As such, the politics of representation is a crucial element in poverty discourses (Lister 2004:110). For example, equating high levels of welfare payments among Aboriginal people with problematic welfare dependency can represent Aboriginal people as the stigmatised ‘other’, morally and practically complicit in their own high levels of poverty and health inequality. The specific targeting of Aboriginal people as welfare dependent, and welfare dependency as a root cause for intractable Aboriginal poverty, also renders the complex and multi-dimensional nature of Aboriginal poverty less visible. Poverty is effectively individualised and the social, economic and political contexts in which that poverty is embedded are obscured. Relevant to the case of Aboriginal poverty and Aboriginal health disparities, is Lister’s (2004:102) suggestion that such ‘othering’ of the poor is most marked where inequality is sharpest.

### ***Social determinant theoretical perspectives***

Also of relevance in understanding the role of poverty in health disparities are two recent social determinants theoretical perspectives that move beyond examining the income inequality and health connection. These models incorporate a broader understanding of poverty and its links to poor health, alternatively proposing a psychosocial or a neo-materialist explanation. The caveat here, as Turrell (2001) cautions, is that much of the evidence comes from the United States or the European Union and is not necessarily able to be transposed to the Australian situation. Their applicability to the Aboriginal Australian situation is even more tenuously proposed.

### ***The psychosocial perspective***

From the psychosocial perspective, Wilkinson (1999; 2002) suggests that in the developed world social determinants have their major effects through psychosocial pathways rather than exposure to material hazards. The biology of stress and key psychological risk factors such as social affiliations, early emotional development and social status are interlinked. Within this, it is relative inequality—that is, income inequality as a marker of social status rather than as an indicator of material wellbeing—that explains the social gradient of health. Negative social status comparisons, quality of social relations and early childhood emotional experiences, it is argued, lead to chronic stress and

subsequent health inequalities. The solution, according to Wilkinson (1999), is to implement employment, income and education policies that reduce the overall burden of disadvantage. Reducing relative societal inequality, that is the gap between those with lower and higher incomes, will enhance a population's psychosocial welfare and thus improve health inequalities.

From an Aboriginal social determinants of health perspective, psychosocial theory offers a plausible explanation for at least some Aboriginal health inequality. Ongoing psychosocial stress is a significant aspect of Aboriginal lives. The central concept of the theory—that an individual's socio-economic situation reflects their social prestige and that this status is reinforced in daily interactions which, in turn, influence psychological and physiological wellbeing throughout the life-course (Veenstra 2005)—has resonance with an Aboriginal social determinants perspective. Being an Aboriginal person in contemporary Australia adds an extra negative dimension to the experience of low social status and prestige as well as low material wellbeing. This whole-of-life course negative experience of social inequality and low social prestige translates, via psychosocial pathways, into poor health and a high burden of disease at the individual and group population level.

The applicability of the psychosocial perspective to an understanding of the social determinants of Aboriginal health, however, is limited by its individualist focus. The theory fails to address the 'whole-of-community' dimension of Aboriginal poor health and poverty. To increase its relevance, the theory would need to be widened to examine group inequality and the impact of that inequality on the sub-population's health outcomes. Additionally, greater income equality within Australia, as a whole, is unlikely to impact upon Aboriginal health unless such income equality is extended to cover Aboriginal people. Based on previous discussions of the manifestly different nature of Aboriginal poverty, this is an unlikely outcome into the foreseeable future.

### ***The neo-materialist perspective***

Of more relevance are those recent theoretical frames that 'bring back the social'. As Lynch *et al.* (2000) state, income inequality cannot be the starting 'social fact' of health inequalities discourse. The shape and extent of inequality comes from somewhere and a neo-materialist approach explicitly recognises the influence of the political and economic processes that generate income inequality (Lynch 2000). Hence, interpretations of the links between income inequality and health must begin with the structural causes of inequality, not just perceptions or measures of relative disadvantage. From the neo-materialist perspective 'health inequalities result from the differential accumulation of exposures and experiences that have their sources in the material world' (Lynch *et al.* 2000:1202). The effect of poverty on health is a reflection of the effects of negative exposures and lack of access to resources for individuals combined with a systematic under-investment across a wide range of human, physical, health and social infrastructure. In other words, income inequality is just a proxy for the multi-level impact of neo-material conditions that affect populations and population health.

The neo-material interpretation critiques psychosocial relative deprivation interpretations on four basic grounds. First, Lynch *et al.* (2000:1201) argue that the psychosocial/social cohesion interpretations conflate structural sources of inequality with their subjective consequences. Second, the perspective underplays the ambiguity of health consequences of tight social networks, with evidence suggesting that while network ties can enhance health, they can also be detrimental. Third, a mostly horizontal definition of social capital ignores the crucial role that vertical institutional social relations have in structuring the social environment in which informal relations exist. Fourth, the decontextualised nature of the psychosocial approach can be appropriated into political agendas, leading to claims that poor communities' health and income inequalities result from social or other deficits within a community and that communities must solve their own problems. These critiques are all relevant to any analyses of the link between Aboriginal poverty and Aboriginal health.

Coburn (2000; 2004) takes a more definitive neo-materialist stance, looking to the rise of neo-liberalism to explain rising levels of health inequality in the developed world. By neo-liberalism, he means the phenomenon of economic ideologies that include a commitment to minimising the role of the state and maximising that of the market. Also critiquing the psycho-social approach, he argues for a change of focus away from possible social/psycho biological mechanisms to a concentration on the social, political and economic context of the health/inequality relationship. To develop a complete understanding of the income inequality health link, Coburn (2000:41) states that the central place of social forces such as neo-liberalism, the changing welfare state and 'most generally, the relationship between class structures, economies and human wellbeing' must be acknowledged. Neo-liberalism, in particular, leads to both higher levels of inequality and lower levels of social cohesion, and its rising influence across the developed world has also resulted in a decline in the inequality-ameliorating role of the welfare state (2004:53).

Critically, Coburn notes that increases in inequality have been more pronounced in countries like Australia that have been classified by Esping-Andersen (1990) as liberal welfare state regimes. These countries have also been the most stringent in adopting neo-liberal, market-oriented political ideologies and policies. The welfare state, with all its defects, does operate to lessen the impact in inequality, and the decline of the welfare state is removing even the limited buffers such as income support measures and public infrastructure around health and education. Coburn's critique on the likely effect of the downgrading of the welfare state on inequality has significant implications for Aboriginal Australia.

## **Discussion: Advancing the research agenda**

Despite the neo-materialist criticisms of the psychosocial pathways to disease thesis, the two theories—neo-materialism and psychosocial explanations—are more complementary than they are

competing. Turrell (2001), in his analysis of both theoretical frames, argues that neo-material factors are the primary determinants of the relationship between health and income inequality, with psychosocial and social cohesion effects just one consequence of these social structural processes. Both theories, therefore, are important in developing an Aboriginal social determinants of health perspective.

The specific value of the neo-materialist approach to an Aboriginal social determinant of health research agenda, however, lies in its recognition that the relationship between health status and poverty is more sociological than epidemiological. The underpinning theses, that income inequality is a manifestation rather than a cause of a wider set of historical, political, cultural and economic factors, resonates with understandings of Aboriginal poverty as different, multi-faceted and fundamentally related to Aboriginality. Under the neo-materialist model, income inequality is only a proxy for wider social conditions that operate through individual, collective, communal and material pathways. Moreover, social and economic determinants are the products of social, political and economic processes, not social facts in themselves. A connection, therefore, might be drawn between the lack of attention paid to Aboriginality as a causal factor in Aboriginal low socio-economic status and income inequality, and the lack of attention paid to the macro context of health inequality. In both cases, associations and relationships among particular social variables tend to be drawn out without consideration of the broader social, political and economic context in which they are embedded. Aboriginal poverty and Aboriginal health inequality both have social structural underpinnings and both are compounded by, and inextricably interwoven with, the impact of Aboriginality.

A neo-materialist perspective also offers a way forward in our thinking about Aboriginal poverty and health. Placing the breadth of issues and concepts relevant to making sense of this relationship within a broad neo-materialistic framework allows us to move beyond the paralysing complexity of the linkage. As Anderson (2001:248) notes, there is currently no existing theoretical or empirical work that is specific to the 'social and historical context of Aboriginal health in Australia'. In developing what Anderson refers to as a more culturally appropriate model of the social epidemiology of Aboriginal health, we need to explore new research and theoretical paradigms. Conceptualising Aboriginal health from a neo-materialist perspective makes it clear that the major determinants of Aboriginal health inequalities occur in sectors other than those directly and immediately related to health.

From a research perspective, this means an explicit focus on determining the broader social, political and economic nature of the relationship between Aboriginal health and Aboriginal poverty. Given the previous discussion, the pathways and mechanisms that link income inequality with health are likely to be very different for Aboriginal Australia than for non-Aboriginal Australia. Specific research projects might examine Aboriginal health from the perspective of wider structural variables such as

levels of government services, and investments such as transport services, road conditions, recreation facilities, health and social infrastructure, quality primary health care, and capacity to access employment and education options. Concepts and constructs such as Aboriginal community control of resources and infrastructure, health, social housing and the environment also need to inform the research framework.

Work is also required to develop different ways of conceptualising, operationalising and understanding the dimensions of Aboriginal poverty. The most commonly used methods both of measuring and analysing poverty are likely to be unsuitable, and, more critically, inaccurate when applied to Aboriginal people and Aboriginal poverty. Any understanding of the link between Aboriginal health and Aboriginal poverty requires appropriate methods for capturing the scope and extent of that poverty. For example, specific equivalence scales are needed to allow a genuine comparison of Aboriginal and non-Aboriginal households. Other indicators and measures of poverty and material wellbeing that can take into account the social, economic and political milieu of Aboriginal lives, as well as those aspects of life that are fundamental to Aboriginal material wellbeing, are also required. The paucity of reliable, comparable and available data on Aboriginal health and manifestations of poverty underscore the difficulties inherent in these and other related tasks. Census data are limited and administrative collections from places such as hospitals, housing and welfare agencies and criminal justice systems are prone to high levels of inaccuracy. Additionally, ‘small percentagisation’—whereby the Aboriginal sample of even a large-scale national health and social survey is often too small to generate reliable results or results that can be disaggregated below national level—is also problematic. Separate ABS surveys, such as the NATSIS (1994; 2002), overcome some of these issues but are still prone to low data comparability with non-Indigenous survey data.

Research from a neo-materialist perspective would also be timely. Australian social and economic policy is increasingly treating Aboriginal people as if they were just another group of poor Australians. What is needed is an evidence-based research program that examines the mechanisms by which poverty and health inequities are interwoven for Australian Aboriginal people.

## **Conclusion**

From whatever perspective poverty is measured, Aboriginal people are heavily over-represented among the poor of Australia. Given this, there is little doubt that the desperate state of Aboriginal health must have an association with embedded Aboriginal poverty. Untangling this link between Aboriginal health and poverty, however, is not straightforward. Considerable exploratory work—using research and theoretical paradigms that incorporate within their foundations the social, political and economic consequences of being an Aboriginal person in contemporary Australia—is required. The



various perspectives on the socially determined links between poverty and health outlined in this paper offer possible ways to move this research agenda forward.

**Endnote:**

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